CASE TAKING

The preamble: The client nearly always has to make contact first, and this is an excellent opportunity for your first 'glimpse' at what needs to be cured; this is the first interaction with someone who needs some healing. Often, that first contact will be by telephone – they will be asking for an appointment, information about Homeopathy, they want to know if you can cure them of ???? You talk to them, taking note of how they present themselves (even over the phone as this can be very illuminating and informative) and in the nicest possible way, you ask them to tell you what their presenting complaint is. This is the second 'glimpse' at what needs to be cured – this will be uppermost to them, the most important issue and one should never lose sight of that. Even if it is a seemingly trivial physical complaint, it is what they are coming to see you about. Whatever the underlying cause or origin of the complaint, this is someone whose vital force has produced these symptoms, specifically to them. If the presenting complaint is a diagnosis or diseased name that you have little or no knowledge about it is imperative that you acquire as much knowledge as possible. You need to know all the common symptoms pertaining to that disease so as to elicit unusual ones as these might be characteristic to the person and thus essential to the homeopathic case. You also need to acquaint yourself with the progress that the disease might follow and what to expect of it. So, already you know a bit about the person but before this person comes to see you, you have to be confident that you can take on the case. Do you have the expertise necessary to see them through. If it is a complex case with deep pathology, do you have the time to give to the case – they might need daily contact, can you offer that; they might require a home visit, can you offer that? Is there an allopathic prognosis as well as a diagnosis, if so you need to be aware of what actually can be achieved in each case – if there are any limiting factors or boundaries that can or cannot be dealt with. Be open minded about any possible blocks you might have towards a potential client. The initial contact will have provided an opportunity to become aware of any. Whatever the situation, you are about to enter into a contract with someone and, as each case is individual, the requirements will not be routine. Make sure you are both clear about what is on offer and what is required. Then you can go forward to taking the whole case. If in any doubts it is sometimes better to refer the client to another Homeopath. Many Homeopaths send their new clients a form to fill in which will supply background information such as any previous treatment and remedies; any surgery; vaccinations and reactions; previous medical history;

childhood illnesses; any medications and/or supplements; family medical background etc. I also include what I call ‘a head to toe’ list which I ask clients to tick if they are relevant. This list might include: vertigo, headaches, eyes and vision, ears and hearing, nose/nosebleeds, mouth and taste, nails, throat, glands, respiratory, coughs, palpitations, hot flushes, varicose veins, haemorrhoids, ulcers, bowel or bladder problems, skin conditions. Any ticks mean you can pick up on these during the case taking. The reason I do this is because it is often easy to forget to ask about these things during homeopathic case taking which can be long and sometimes upsetting experiences. Sometimes we just run out of time and yet if they have written a history of eczema of the form but would other wise have failed to tell you about it, this could make or break a case. Some Homeopaths ask many other questions on these forms which delve into emotional and social issues which I, personally, do not think is a good idea as it pre-empts information that the client might volunteer and this method would be far more valuable. These forms should really only be for background information.
The Presenting Complaint: What is the presenting complaint exactly? Classical Homeopathy teaches us the notions of ‘totality of the case’ and to place considerable emphasis on the emotional and mental planes of the case (sometimes more so than the physical), but what does this do to the all important presenting complaint – this is what the client comes to see you about. Whether the presenting complaint is on the physical, emotional or mental plane, first and foremost it should be given priority in the case taking. The client will WANT to talk about this primary condition, it will be what they are reacting to, have feelings about and they will have intimate knowledge about it – whether it be an acute case or a chronic case. Even the most taciturn of clients will be more familiar with their condition than anyone else, so this is where the case taking should begin. The whole essence of the case is within the presenting complaint and often there is little need to go outside of it. Even if the aetiology of the case was many years before, by dealing with the presenting complaint, by curing it (NOT making it disappear by suppressing it), you will automatically be incorporating the aetiology and thus dealing with it. Thus, the totality of the presenting complaint is the biggest set of clues that the vital force can give us as to how to cure this person. Whatever style of case taking we develop over the years, volunteered information is always the best because the client is prioritising for you – the first words they utter will always be of prime importance (as too will be their actions when they first arrive and enter the consulting room). After greeting the client I nearly always say “I would like you to tell me why you have come to see me and then I

will probably ask you some questions." And off they go. Unfortunately, this can come to an abrupt end after just a few minutes. People new to Homeopathy are not always used to how much information we require from them. In these instances it is best to just keep prompting them, just keep asking them to say more, until it becomes obvious that questions need to be asked. If you have a loquacious client it is still best to let them talk for a while. You have to learn to write with lightening speed (or make keynote headings) and then at the most appropriate point, if you are not getting a clear picture, you have to interject to contain the case taking. Remember that not every loquacious person requires Lachesis! There will always be a substantial amount of peripheral information during a case taking. You will be using your observation skills regarding their appearance, stature, gestures, odours, habits, voice quality, communication skills, whether they were early or late in arriving, whether they take their outer clothes off, how they make themselves comfortable on the seats etc. You might want to shake their hand during the greeting to get an idea about their body temperature and other dynamics of what a handshake can tell you. Other important peripherals could be items they bring along such as notes they have made; samples of allopathic medications; bodily samples (believe me it happens!). If the client is a child they will bring one or both parents (very important); sometimes it might be a grand parent, and if that grand parent has a lot of responsibility in bringing up the child then they too are an important part of the case taking. Overall, whatever the client chooses to bring with them and how they present themselves will be an indication as to their state of being. Specific Questions: These are fundamental to the case and should always be asked and answered. I have used the word "pain" here to represent the presenting complaint, which could, of course, be anything.

LOCATION – where is the pain or origin of the complaint + all modalities. The origin of the complaint might link also to the causation (see below).

EXTENSION – what other parts does the pain or complaint travel to + all modalities.

SENSATIONS – the words they use to describe what and how they feel are vital to the case as they can open up the underlying delusion, or the driving force behind the case. Always go as far as you can with this part of the case taking. If, for example, someone describes the pain as "floating" – ask if this is a sensation they experience in other aspects of their life, in dreams, in lifestyle, in vision, in other parts of the body etc. Someone who has Rheumatoid Arthritis might describe the pain as "crushing" – thus, you need to know if, indeed, they have been crushed

emotionally at some point in their life. You also need to know if the sensations are directly linked to the locations, extensions and even more the causation – sometimes they are not. Again, all modalities have to be included.
CAUSATION – ask if they can connect the cause of their complaint to any time and/or incident and then follow through thoroughly with whatever they offer. This is often a good time to ask about any traumas they might have experienced in life and how they have dealt with them. Never rush this part (or any part of the case taking) as often they will say they cannot think of what might have caused this state because they just do not want to go there – a potentially dark or unhappy place. But you have to go with the flow and allow or prompt if you think there is valuable information there. If at this point you do embark on an upsetting journey with the client make sure that, towards the end of it, you bring the case back to more mundane matters so that they are not left dangling, emotionally. Sometimes there is genuinely no known causation and it is futile looking deep into the case for clues – move on to other aspects of the case.
CONCOMITANT SX – ask if they have any other symptoms which seem unrelated to the presenting complaint. You will need to know your pathology here so as to separate out common symptoms from unusual symptoms. Again, include all modalities.
MODALITIES – try to cover as many as possible and always ask about amelioration as well as aggravation, and include the following: Temperature Weather and air Bathing – hot and cold applications Touch and pressure Light, noise, odours (all external stimuli) Times of the day and night Rest and motion Position – standing, sitting, lying etc Eating and specific foods/liquids I would also include what reaction there is to consolation in this part as this can provide another entry into the case from an emotional point of view, if this hasn't already been approached.
PACE AND REACTION: It is vital to know at what pace the diseased state began and continued – whether sudden or slow and the duration of the attacks if this is relevant. Individual reaction to the emergence of the presenting complaint has to be enquired into – again this will give vital information as to the emotional and mental state of the person. What you are looking for, overall, is how the presenting complaint has CHANGED the person. Other considerations: What organs are involved What is the underlying pathology Do you need to perform any kind of physical examination Is there an aetiology or a 'never been well since' situation Is there a distinct timeline you can make use of, i.e. one that provides an insight into the case. This last point can be interesting in as much as the presenting complaint might not be entirely in the 'here and now' – the 'here and

now' providing a crisp circular case. The presenting complaint might stretch back quite some time, with interludes of health – this creates a more oval shape to the case. And, the presenting complaint can stretch back even further, many years, thus making a hard edge oblong shape to the case. Giving a shape to case can be helpful in not only containing ALL your notes but also indicating the underlying miasm, essence and core of the case and even potential remedies that will lead to the simillimum. Other areas to explore the presenting complaint (in view of all the above notes): Daily activities and routine Mental activities and memory function Confidence Relationships with others (include sexual energies if relevant) Temperament – anger, jealousy, anxiety, sadness etc Their 'vision' of themselves, ambitions reached or otherwise Fear and phobias General energy Physical generals – all food and drink cravings, aversions, aggravations and ameliorations; menstrual history if relevant; sleep type and requirements, position, pillows, snoring, quality, cat naps etc; dreams; clothing preferences and any dislikes; temperature and weather preferences and any dislikes; bladder and bowel function and the rest of the 'head to toe' questions (especially skins and warts); medical history; vaccinations; check for any serious pathology of immediate relatives and, if deceased, how they died. Medications – always take a note of any drug being taken and always take time to find out the known reactions of the drugs as these can alter many states. For example, you have a case that you are convinced is Pulsatilla but the person is extremely thirsty, so you give the next best choice of remedy which does nothing. You choose another remedy, possibly another after that until you realise that they are taking a drug which makes them very thirsty and the case was always Pulsatilla. Towards the end of the case taking it is always worth asking, "is there anything else". Surprisingly, this can be when the real case begins. Finally Keep the mind open but focussed Always be curious – one of the most important questions during case taking has to be "Why?" Understand the human condition Do not judge or indulge in too much interpretation Accept the symptoms for what they are. The stance of the Homeopath throughout the entire case taking and treatment has to be that of an unprejudiced observer.

When taking the case, be aware of these hinders:

1) COMPARING - this makes it hard to listen because you are always trying to assess who is cleverer, more competent, more emotionally healthy - you or the client. You stop listening because you are too busy seeing if you measure up.

2) MIND READING - the mind reader doesn't pay attention to what is being said, in fact it is often distrusted. They are trying to work out what the client is really

thinking and feeling. The homeopath's notions of the other person are often born out of intuitive hunches and vague misgivings.
3) REHEARSING - you don't have time to listen when you are rehearsing what to say next. Your attention is on preparation and crafting of your next comment. You have to look interested but your mind is going a mile a minute.
4) FILTERING - when you filter some things go in and a lot doesn't. You pay only enough attention to see if somebody is angry or unhappy or if you are in emotional danger. Once assured that the communication contains none of these things you let your mind wander.
5) JUDGING - if you pre-judge someone as stupid, neurotic or unqualified you don't pay enough attention to what they say. Any form of prejudice is a judgement. You have already written them off. A basic rule of listening is that judgements, if necessary, should only be made after you have heard and evaluated the content of the message.
6) DREAMING - you are only half listening and something the client says triggers a private train of thought. Boredom and anxiety can lead one to start dreaming - a big effort is needed sometimes to stay tuned in to what the client is telling you. Dreaming can mean a lack of commitment.
7) IDENTIFYING - you take everything the client tells you and refer it back to your own experience. Everything you hear reminds you of something you have felt, done or suffered, so there is no real time to hear or get to know what the client is telling you.
8) ADVISING - you are a great problem solver, ready with help and suggestions. You don't have to hear more than a few sentences before you begin searching for the right advice. It is a form of repellent, preventing you to getting to the core of the story being told.
9) SPARRING - this has you arguing and debating with your client who never feels as though they are being heard because you are too quick to disagree. You take strong stands and are very clear about your beliefs and preferences, which hinders the progress of the consultation.
10) BEING RIGHT - you will go to any lengths to avoid being wrong, you cannot listen to criticism, you cannot be corrected and you cannot take suggestions to change. Since you won't acknowledge your mistakes you keep making them. Frequent wrong prescriptions are an indication of this.
11) DERAILING - this is accomplished by suddenly changing the subject, you derail the conversation when you get bored or uncomfortable with a topic, or you

manage to joke it off. This can be very disconcerting to a client who might then feel alienated.
12) PLACATING - you want to be nice, to be loved and appreciated by your clients, so you agree with everything.
13) BOMBARDING - you impose unnecessary methods or skills onto your client to impress them - examining them, taking blood pressure, using fancy medical equipment, etc. You want your client to believe you are more practised that what you really are, a way of overcoming an actual lack of confidence or a show of arrogance.
14) RUSHING – you are in a hurry for a variety of reasons and so you rush through the case and aim to give a 'quick fix' solution because you don' t have time to spend on the case. You feel you HAVE to prescribe there and then even though you are not entirely sure of what remedy to give or you are falling into the trap of routine prescribing. One often has to 'think on your feet' especially when prescribing for acutes and sometimes for chronic cases as well, but you still must be reasonably certain of the remedy choice, else why give it at all.

Expanding the case: The case has been taking and you now have copious notes, numerous pages of valuable information but some of which will be misleading. Sample case: Female, 38, comes with pre menstrual tension. She talks mainly about mood swings, blowing things out of proportion at some time during the menstrual cycle, nearly always before menses. The little things become big. Her main emotions are irritability, frustration and can be weepy. Has been like this for many many years. Periods have never been regular or even monthly. She knows the instant her period has begun because her mood lifts. The flow is heavy for the first few days then slows down. Nothing helps the mood swings, she pushes friends to the limit, has to push the friendship to test it. Can't connect with people. Had a same sex relationship with a relative some years ago and has never got over this. She loved this person but it got complicated and the other partner moved away and in the end she herself had to finish the relationship because it was too upsetting just waiting for her partner to come back into her life. She still has not got over this and she has no idea about her sexual identity. Very depressed after this, now always testing relationships. She is an artist and teaches at a college and in a prison. Shows me some of her drawings, all done in ball point pen ink and are either black, blue, with little colour – extreme detail and intense. Has had lots of temping jobs. Hated school, was bullied, humiliated. In confrontation she will fight back but her temper can seethe and bubble, tends to

hoard problems then chooses the wrong moment to express discontent. Not a weepy person but can get choked up with emotion. The thought of animals dying upset her terribly. She likes the idea of tragedy and love combined = intense. She wants excitement and stimulation not mundanity. When at the cinema she lives out the parts. Likes to go to festivals, does charity work, loves gardening, walking, visiting art galleries, wants to be an artist. Has to be busy, works to an intensity until resolved then weary but energy is generally excellent. “Burn out” – all or nothing. No real fears, except that something might happen to her parents good relationship, loves seeing them. Has a huge appetite at some points in the month, this is up and down. Is vegetarian but craves fish, smoked fish, tuna, likes the salt and brine, chilli gherkins, lime pickles. Averse to fats. Can crave chocolate and ice cream and red wine. Not very thirsty. Prefers to be warm and comfortable, hates the winter, intense heat <>. They start in the back of the head and rest over the forehead. Pressing, tight pain but pressure >>. Has neck problems from carrying so many heavy bags around with her. Mornings are not her best time of day. Father has kidney stones. She used to get ear infections as a child and swollen glands but now ok. Occasionally get haemorrhoids. She is quite tall, average build, dark hair, slightly sallow skin, wears dark clothes. Sits with legs crossed but looks comfortable, keeps jacket on (room could have been warmer). Talks well but sometimes speech has a nervous sound to it. She is also having therapy.
Throughout the consultation a great deal of emphasis was placed on her unknown sexual identity, feelings about the relationship and the love she has lost and the moods swings associated with the menstrual cycle. That is the case and this will be used to work though the most important aspects of reviewing the case and how to extract the significant information. Everyone must develop their own style and methods of case taking and analysis but the case should be ‘contained’ in some way, it has to be ‘sifted’ to put aside information that really is not needed. You can use the sample case to practice that in a variety of ways that suits you or ones that you can experiment with to see if the result is the same.
Try to include the following points:
1) What is happening to this person?
2) What needs to be cured?
3) What are the leading rubrics that might define the case?
4) What are the supporting rubrics that are essential to the case?
5) How many rubrics should be used?
6) What is the hierarchy and grading of the chosen symptoms?
7) What is the totality of the case – what does this really mean?

8) What emphasis should be placed on the mental and emotional symptoms in context with the physical symptoms?
9) How are the mental and emotional symptoms related to the diseased state?
10) Is the case muddled – what dominates or drives the case? We could begin with 'shaping' this case as was mentioned in the first part of these case taking notes. This case appears to be in the here and now, i.e. it does not seem to extend beyond a maximum of a few years that tie in with the relationship she had and is still suffering from. The perfect circle case? As soon as a case has been taken and you feel confident that you have enough information, or at least, you have taken the client as far as possible, you can tell them that you want to spend some time working on the case and they can come and collect their remedy the next day, or whatever arrangements you make. When the client has gone, and before the next one arrives, this is THE best time to shape and evaluate the case, while it is still fresh in the mind. This is best done in the form of a brief summing up – mainly using the 10 points above.
Thus we would arrive at:
1) This person is stuck in 3 ways. She cannot resolve the lost love; she is unclear about her sexual identity; she has hormonal problems which result in moods swings and menstrual disorders. There is a need to be stimulated, excited and 'burn out'. Intensity dominates the case. Her uppermost emotions are irritability and frustration. She pushes relationships to test them and has some difficulty in connecting with people even though she has a good social life and is busy ALL the time. There is a tendency to hang on to the past.
2) Her presenting complaint revolves around the mood swings and menstrual disorders – this is what she came to see you about and this is what she wants to be cured. She also volunteered to talk about other important issues in her life and, as homeopaths, we know how valuable that extra information is, but what matters is how we deal with it .
3) and 4) As an experiment, let's build 2 cases out of one, by choosing 2 leading rubrics and 2 sets of supporting rubrics, both of which will appear to fit the case but only one of them will find the simillimum. Case A Ailments from disappointed love Ailments from grief Dwells on the past Grief, cannot cry Consolation <<< Irritable Anger from trifles Fear of being rejected Confusion as to her identity Menses irregular and profuse Aversion to men Alternating mental states Craving for fish, salt, sour, chocolate, ice cream Averse fats and meat Pressing headaches >>> pressure Anxious dreams <<< strong emotions <<< morning cold <<< CASE B Chronic hormonal disorder, never well since puberty Mania before menses <<<

menses Quarrelsome Menses irregular and profuse Frightful dreams Dreams of being chased In love with own sex Busy, needs to be Work >>> Craves pickles Averse fats Cold <<< Sitting with legs crossed >>> Which of these would you choose and why? What are the remedies that are coming through? What is the simillimum for this case?

5) Sometimes a case has far too many potential rubrics. If carefully selected the simillimum can be found with just a few rubrics, but I think the above examples are adequate and correct, i.e. one should be able to find the simillimum with a maximum of 8 – 10 rubrics.

6) Grading symptoms and giving them a correct hierarchy, as shown in the above examples are vital to the case. One of the above examples begins where the case actually begins – the other begins at another strong point in the case but makes an error in the aetiology. It gives a high grading to a symptom that neither defines the case nor exhibits a causation. One of the examples gives far too much emphasis on emotional aspects of the case and places too little emphasis on the presenting complaint. One of the examples makes a crisp circle as the shape of the case and the other makes an oblong. One example has ignored the peripheral information of the case that often cannot be repertorised but CAN be read in the Materia Medicas and it is here where the best remedy is chosen. It is never enough to grade and rank symptoms and then select the remedy which comes out on top if, when reading about the remedy in the Materia Medicas, it does not fit the case. If the leading rubric is chosen correctly and other rubrics follow through the simillimum will always be there somewhere, in some cases it will even repertorise out as being the lowest ranking remedy, but the fact is, it is there.

7) What is the totality of this case and what does this mean. Totality is the whole diseased state and NOT the whole of the healthy state. Many cases are actually a fusion of both a healthy state that is in decline and the diseased state and they do need splitting up. But there is nearly always a third category, that which binds the healthy to the diseased, that which is caught in between. For example, if someone says that they love to go out walking in the hills as a leisure activity – is this part of the case or not? If they say they have to go out walking in the hills, they feel driven to it and to not do it would probably make then feel isolated or oppressed etc, then this is definitely part of the case. This is ranked highly because it is a strong symptom, something that drives this particular person. Likewise, with our sample case we have information that appears peripheral but is actually essential to the case. The real totality has to include information that you might initially

want to leave out, that which cannot always be signified as being symptoms – this is the fusion. You might want to make you own list before looking at what follows. . the little things become big – this is her clue to you to look deeper at the little things in this case . her period flow begins heavy and then slows down = intense then calm . she tests relationships = she likes to tease people, takes pleasure in it, pushes them to a limit . in this same way she actually had control over the relationship by ending it herself, not the other way round . she is an artist and uses only ink, dark coloured mainly blue and black, her drawings are very detailed – the little things again . intensity is referred to throughout the case = mood swings . there is a need for excitement and stimulation . she works in a prison (how do you use this?) . she has a 'thing' about fish . she dreams about being disconnected from an emergency call (how do you use this?) . she carries heavy bags around with her, they contain her work mostly . she sits with her legs crossed All of the above is vital when using this case as a sample and you know what the simillimum is and look back. In many ways the above points are THE WHOLE CASE. Could you get to the simillimum with this? You could if the emphasis was put in order. This person requires stimulation, excitement and intensity because she is stuck, there is a deep controlling stasis. This is why the little things become big. This is why there are mood swings. She feels the need to test people and push the relationship into jeopardy. She is an artist using dark inks. She has a 'thing about fish'. She sits with her legs crossed. These 5 points actually give you the simillimum. The case has been expanded, given emphasis and then put back together again in a minimal manner without doing any damage to the vital information– the essence of the case, using only the peripheral information.

8), 9) and 10) In this sample case the emotional symptoms have equal standing with the physical symptoms, they are mutually dependent. There are no mental symptoms in this case. This isn't always the case and it is basic good practice to recognise and sort out the 3 planes in every individual case and learn to see if there are any links between them. Using 3 parallel columns and placing the relevant symptoms into either physical, emotional or mental, can be very pragmatic and revealing and often this helps create their own true context. Having sorted the symptoms by plane you can then try linking them to the presenting complaint, but do not force any links. Try this soon with a case and see what happens. It is essential that a case is taken for what it is – there may or may not be any strong or obvious connection with the 3 planes; the case may be entirely driven by one plane. But either way, keep it simple, do not force potential

symptoms into a case as this can be so misleading. Allow symptoms to voice their own level and strength by frequently asking “what needs to be cured” and “how are all these symptoms related” (bearing in mind that the answer to this should – the presenting complaint). If these two questions cannot be adequately answered then the third question has to be “what drives this case”? All of this before you have even begun to select rubrics!! Of course there are many other considerations to make before the first prescription. After, and some times during case taking, assess the case AND the person, their needs in context of their life. Decide on your strategy, which in some cases may include something other than just a homeopathic remedy. Consider the vitality of the person in terms of energy and how they present themselves, their appearance etc. Ask yourself, “how clear is the symptom picture”, both from the point of view of the quantity of symptoms (vitality) and quality of symptoms (ranking). Is there any suppression, either emotional or medicinal. Are there any layers to consider. Is there a dominant miasm or is it mixed, heavy or light. Are there any weak organs – where is the main susceptibility. Is there any ‘never been well since’ or aetiology to consider. What part does any other medication play. Is there a history of acutes and/or other chronic illness to consider. What degree of sensitivity is involved. What are the possible maintaining causes or stress factors to consider. Is there an allopathic diagnosis and/or prognosis. How do you rate the ‘happiness’ factor, along with a sense of ease, state of awareness, ability to change, level of morbidity, service to others, and feelings about the self. Considerations of potency and case management. And above all, what kind of symptom picture have you got – what sort of person is it. Do these match?

Case taking is all about extracting symptoms and symptoms have to have a quality to them and be the FACTS of the case. The aim is a minimum number of symptoms with the maximum importance and relevance to the case. Taking the totality of the case doesn’t mean including every single detail of the person’s life, it merely means the totality of the signs and symptoms pertaining to the diseased state. There are various methods of doing this but separating symptoms into the following categories is extremely valuable and practical. Physical Generals – these are the specifics of the person; reactions to temperatures; sensitivities; discharges; suppressions; menses; sweat; sleep; appetite; restlessness, chills and fevers; pains; aggravations and ameliorations; objective symptoms such as colour of orifices, odours, appearance and gestures; pathology, which should include all susceptibilities. Mental and Emotional Generals – these are the mental and

intellectual abilities (or lack of) which should include levels of understanding and confusion, memory and concentration, loss of time sense, delirium, delusions; and all the emotional qualities including love, hate, revulsion, suspicion, desires and aversions, fears, dreams, sexual energies, social attitudes, ability to laugh and cry, reactions to being ill, compulsions such as smoking, drinking, drugs etc. Particulars – these are the symptoms that are important to the client, those that are prefixed by "My….". These symptoms can be very meaningful because the client will be relating to them intimately and are often the symptoms they will talk most about. Strange, rare and peculiar – these are the symptoms of which Hahnemann says, "the more striking, uncommon and peculiar (characteristic) signs and symptoms of the case of disease are chiefly and most solely to be kept in view, for it is more particularly these that very similar ones in the list of symptoms of the selected medicine must correspond to, in order to constitute it the most suitable for effecting the cure". Striking, uncommon and peculiar symptoms can appear absolutely anywhere within the case. It might be the modalities of a case, the sensations, the location (if not generalized but specific). They can be cravings or aversions, dreams or fears. They might appear as seemingly small symptoms but nonetheless significant. For example, a burning sensation which is >>> heat; a dry mouth that has no thirst; nausea which is NOT >>> for vomiting; a fever that has no thirst, etc. Likewise, a single characteristic symptom can dominate a case to such a degree it virtually leads the case easily to the simillimum. For example, hands covered in warts; cold hands alternating with cold feet; a pain in the heart only in the late afternoon; a weakness of memory for dates only, etc. Just open your favourite repertory and concentrate on a single chapter and mark up as many striking, uncommon and peculiar symptoms and compare them to all the other, much less remarkable symptoms in that section. I think a big question to be asking is whether the 'essence' of a case can also be found within these uncommon, peculiar or characteristic symptoms. One can only answer this if you take time to draw lines within each individual case. For example, there are hard tumors present and a line c an be drawn to the emotions, which are also 'hard'; overall the person is plump and soft and a line can be drawn to their excessively yielding nature (the door mat type); the discharges are bland and a line can be drawn to the 'weakness' of the person; the child spits at people and there is a direct line to their deep fear of snakes; the body is stiff all over and so are the emotions; the temper is explosive and there is a line to deep suppression, etc etc. One can cite endless examples and be tempted to say that the essence of a case can be summed up with a striking, uncommon and peculiar

symptom. But if this route is practiced it has to be done on a factual basis and not in an interpretative manner which is open to much speculation and judgmental psychoanalysis. Symptoms of Local Diseases – unless they are entirely due to external injury, you have to remember that all external expression of disease comes from within. In these instances there will still be generals, particulars and characteristic symptoms to be found. Include all marked modalities of symptoms, whichever category they belong to. General and undefined symptoms or vague and indefinite symptoms should not be included directly in the case but put to one side. These types of symptoms might be indications of a deeper layer, they might also be meaningless, they might even be the symptoms which develop after the first prescription which in turn will shed light on the case, but initially they should be left to one side. Confusing symptoms, due to drugs, poorly elicited because of the client's state, damaged by previous remedies or suppression in some way should also be put to one side. Sample Case Female, 44 years old. Presenting complaint = heavy menses on first day then they tail off to a pale discharge; headaches for several days before menses; the headaches are described as throbbing and hitting and <<< open air, light and noise; some uterine pain on first day of menses, also bloating, otherwise the period is regular. Used to be irregular and was told this was due to an over active thyroid gland. Has had 3 children, now averse to sex after last child. Complains of being tired most of the time, especially after her period. Has some joint pains, says they feel tired, <<< mornings. Joints get swollen and sensitive at least twice a month. Occasional dizziness, twice a month also. 5 years ago she had an open ileo-caecal valve and was given medication for the stomach pain. Remembers being bloated and her stomach rumbled all the time. Has had a weak bladder and frequent cystitis following births. Can be a compulsive nibbler, <<< pastry, fruit, heavy foods, spices, eggs, fats, milk, cheese. Craves nuts. Tendency to loose stools and diarrhea. Not very thirsty. Has difficulty going to sleep, thinks about all that has happened to her and likes to alter the events in her mind. If things have not been good she will relive the events and change them. Wakes at 3 am. Dreams of vivid colours. Feels good in the morning on waking. Feels the cold, very sensitive to it and also extreme heat. Likes thunder now but as a child used to be fearful of it. History of heavy sweating but not so much now, only when she gets angry. Lives for the now and has few worries but does have anxieties about relationships. She is separated from husband – he was too demanding which made her really irritable which she found hard to cope with as she has difficulty in showing her emotions. Fears dogs, snakes, heights, spaces. Easily upset, doesn't like people

shouting, she is very sensitive to bad atmospheres, she likes peace. Noise startles her, she avoids strong emotions, she is terrified of a new personal relationship. She retreats into herself and prefers to be alone. Consolation can both <<< and >>>. Likes order in her life. This is the case with most of the less significant details left out, and although this is a so called paper case it is a true one and it is an excellent chance to now work on this case – to extract and order the facts into the various categories of symptoms. And, if you feel up to it, have a go at finding the simillimum. There are no real confusing symptoms here and no fancy thinking about the essence of the case. There is no unearthing of deep and unspoken symptoms and absolutely no need to be extravagant with the details. It is simple, factual and straightforward. For those who are not wanting to take this step the symptoms can be categorized as follows: Physical generals = She is chilly (but also reacts to extreme heat) – overall very sensitive H/O sweat and sweats when angry The case is now revolving around menses which are very short and become just a pale discharge Sleep is good and refreshing but she has difficulty in getting to sleep because this is the time when she changes events in her life She has definite cravings and aversions Pains are described specifically as throbbing, hitting Aggravations come in the form of food reactions, light, open air and noise H/O ileo-caecal, cystitis Joints become sensitive and swollen There is a general tiredness but this is < after menses Tendency to loose stools and diarrhea Mental and emotional generals = There are no real mental issues in this case, the emphasis is on the emotions She has been hurt by a previous relationship and has now retreated into herself She has become extremely sensitive to emotional atmospheres (as well as physical ones) She wants to be alone and is terrified of a new relationship Very little sexual energy She has very specific fears and dreams She has compulsions (food) She fantasizes about her life She avoids strong emotions Needs order in her life Particulars = in this instance the client chose to refer to her menses and headaches, sleep and past relationships. Emphasis was also placed on food and temperatures. These are the items that were significant to her and could prove to be the symptoms which become starting points for lines to be drawn from and which link up elsewhere in the case. Striking, uncommon and peculiar symptoms = Periodicity Extremely short menses – pale discharge Throbbing and hitting pains Specific fears Extreme sensitivity Terror of emotional involvement Compulsions Fantasizing about her life at night Dreams Suppression of emotions Need for order If you choose to, you now have some time to work with this case. The same case will be used to move on to the final part of the case

taking notes. In the meantime you might want to discuss aspects of this case and how the symptoms come together.

After the case taking You will have pages of information that now needs to be sifted and sorted and put into a 'nutshell' – the 'nutshell' being the metaphoric shape of the case. Into this shape you place the facts of the case, whether those facts be particulars; generals; strange rare and peculiars; sensations; modalities; locations; extensions; causations; concomitants; disease names, i.e. pathology; miasmatic influence; and, the most important what needs to be cured. Nothing else is really needed but FACTS that have been volunteered by the client, if necessary via careful and unbiased questioning. If you have a busy day and expecting another client to arrive soon after a new case, then take a few minutes to write a summary of the case. Begin with a point of view, such as, "what is going on with this person, what is driving this case?" Add to this, "what needs to be cured?" Also, "when did this case begin, is there a useful history and what was the causation." Before the last session's paper case is used to illustrate the above I will give 2 brief examples of summaries. 1) A recurring migraine case of many years standing, client holds head in hands, there is a deep history of disappointment and heaviness, i.e. duty and pressure to do well, the case is slow and heavy, there has been a history of recurring influenzas, the migraines need curing but the heaviness also needs to be dispersed. The shape is a long, drawn out oval. 2) A child with epilepsy, heavily suppressed but not completely (opisthotonos and head locked sideways are the guiding symptoms), never been well since vaccinations, ongoing ear infections, the child is not reaching milestones, quite hairy, there is a lot to be cured here and is possibly a layered case. The shape is a square (has a straightforward immediacy), the 4 corners representing the different layers which need to be cured. But a summary can be any shape or form and if you are not used to working with these then a straight line will do just as well. You just have to remember that the client can present themselves at ANY point on that line – at one end is the beginning of the diseased state and at the other is deep pathology, in between are all the symptoms of any given diseased state that will correspond to the same symptoms of the remedy. Once these summaries have been made you can put them to one side. Even if you have the time to work on the case straight away it is still worth writing these 'nutshell' summaries. On reflection they can truly sum up the case in a factual, impartial, manner. How far could you go with these nutshells. The first is Gelsemium and the second (although much more complicated) is Thuja, Cicuta,

and Belladonna – with one corner spare for anything untoward. Back to the paper case which has more substance to it. Using the notes from session 3 we can summarize this case as follows: Overall sensitivity drives the case as does fear and terror; there is denial and fantasy; there is compulsion and a need for order; the time in the case revolves around periodicity; the causation was profound emotional hurt – this is what has 'fixed' the case; the past states are important = sweat, ileo-caecal, diarrhea, cystitis; the presenting complaints (very short and pale menses proceeded by headaches, throbbing and hitting pains, swollen and sensitive joints), contribute to the reflection of what needs to be cured = fixed ideas and the need to fantasize. The shape is hard and fixed, a square, with activity in all corners. You might have chosen to repertorise and work on this case and even if you haven't, it is now worth knowing the simillimum to this case. It is China officinalis. I would suggest you read about this remedy and see how easy it is to underline the summary within the remedy symptom picture. These post case summaries are only really intended to contain the case, describing it in as few words as possible. They are not intended to be a direct line to so called essence prescribing. Individual remedies can have many essences supported by a number of keynotes for each, literally, the sum and substance of a case. Essence prescribing often involves going against the facts – ignoring strong symptoms – in pursuit of something more vaguely encompassing. A great deal of time can be wasted by going down this route. Once you have made your summary and contained the case (so it cannot run away from you, as can happen very easily), you can begin to grade the symptoms and form a hierarchy and then start to repertorise. Select the strongest symptoms – and by strong I mean those that dominate the case – and give these the highest ranking. Try to keep these top ranking symptoms to a minimum, just a few. From this group try to pick just one that becomes a leading or guiding rubric. This will be a rubric/symptom which defines the case in as much as there would be no case without it, there will be no case beyond it. It isn't always possible to do this with all cases but it is an enticing experiment to carry out. Let's go back to the paper case and try this out: The highest ranking symptoms would be – (not in any particular order at this stage) Heavy menses on first day then they tail off to a pale discharge; headaches for several days before menses; the headaches are described as throbbing and hitting and <<< open air, light and noise; Has some joint pains, says they feel tired, <<< mornings. Joints get swollen and sensitive at least twice a month. Occasional dizziness, twice a month also. Tendency to loose stools and diarrhea. Has difficulty going to sleep, thinks about all that has happened to her and likes to

alter the events in her mind. If things have not been good she will relive the events and change them. Wakes at 3 am. Feels the cold, very sensitive to it and also extreme heat. Lives for the now and has few worries but does have anxieties about relationships. She is separated from husband – he was too demanding which made her really irritable which she found hard to cope with as she has difficulty in showing her emotions. Fears dogs, snakes, heights, spaces. Easily upset, doesn't like people shouting, she is very sensitive to bad atmospheres, she likes peace. Noise startles her, she avoids strong emotions, she is terrified of a new personal relationship. She retreats into herself and prefers to be alone. Consolation can both <<< and >>>. Likes order in her life. You could summarize the above even further, into She has very specific fears and dreams She has compulsions (food) She fantasizes about her life She avoids strong emotions Needs order in her life Particulars = in this instance the client chose to refer to her menses and headaches, sleep and past relationships. Emphasis was also placed on food and temperatures. These are the items that were significant to her and could prove to be the symptoms that become starting points for lines to be drawn from and which link up elsewhere in the case. Striking, uncommon and peculiar symptoms = Periodicity Extremely short menses – pale discharge Throbbing and hitting pains Specific fears Extreme sensitivity Terror of emotional involvement Compulsions Fantasising about her life at night Dreams Suppression of emotions Need for order Which of these would you choose to begin your repertorisation? Which would you choose for the leading rubric. If your summaries, nutshell and shape have been accurate there are a few you could begin with. These are, after all, facts of the case and you could choose to jump in the middle of them and work outwards and the simillimum will probably appear in all carefully chosen rubrics. My leading rubric would be Mind, fantasies, at night; + with sleeplessness. To this I would add: Mind, fear of being hurt, emotionally Fear of dogs (this was the worst fear) Headaches, periodic; + throbbing Generals, periodicity Menses, pale If you are writing remedies down or using a repertorisation sheet or computer software programs these are more than enough rubrics to be using (6) – and you will have the simillimum. You might, at this point have a few remedies coming through but now you go to the Materia Medicas to read about them. One will fit like a glove (encompassing all the other symptoms), the others will hang loose and can be rejected. Again, have a good read about China officinalis so that you can 'see' this remedy as the simillimum. Without this factual procedure you might well have ended up prescribing a remedy such as Sepia which, arguably, has a strong and indicated 'essence' presence within this case. As a reminder, Sepia

was the simillimum in the first paper case presented in these notes. Finally, to end these notes, I think I should say that I am not totally opposed to essence prescribing. But it has to be done on a factual basis, as I have said before, otherwise a lot of potential healing time can be lost. In the notes of session 3 I mentioned the idea of drawing lines in cases, as a method of developing the essence picture. If we were doing this with this case it might look something like this: A drawn line between compulsion and periodicity (this is all about re-occurrence) A drawn line between the fears and fantasy (this is about being unhappy with her life) A drawn line between the sensitivities and suppression of emotions (this is about trying to find a balance) A drawn line between the need for order and being tired (this is about loss, and China is, essentially all about loss) A drawn line between the fear of being hurt emotionally and throbbing, hitting pains (this is about feeling persecuted) A drawn line between an intense case that has pale menses (this is about the inner self trying to come out).